Affect and Therapeutic Process in Groups for Chronically Mentally Ill Persons

WALTER N. STONE, M.D.

A dynamic group treatment model for chronically ill persons allowing them to determine the frequency of attendance empowers the members and potentiates group development. This format respects patients' needs for space as represented by missed meetings. In this context, absences are formulated as self-protective and self-stabilizing acts rather than as resistance. In an accepting, supportive environment, members can be helped to explore affects and gain insight into their behaviors. A clinical example illustrates patients' examination of the meaning of missing and attending sessions, with particular focus on intensity of involvement, autonomy, and control. In the process of testing the therapist and group, members show capacity to gain insight into recent in-group and extra-group behaviors.

(The Journal of Psychotherapy Practice and Research 1998; 7:208–216)

The ravaging effects of schizophrenic and bipolar illness on thought and affect remain a therapeutic challenge. The multiple biological, social, and emotional needs that are the basis and consequence of severe and persistent mental illness defy simplistic solutions. Medication may alleviate some of the chaos but fails to reverse or halt impairment in essential areas of human functioning—relations with the self and with others from which come a sense of wellness and comfortable regard.

For many patients, the illness may have begun in childhood, even before overt clinical features were present or were of sufficient intensity to justify a clinical diagnosis. Many first-person reports attest to patients' recollections of feeling different, estranged, or isolated from peer groups. Before the onset of a diagnosable illness, impairments may be expressed in the social domain as diminished interpersonal responsiveness, poor eye contact, and failures in expression of positive affect. Subtle motor symptoms add to these individuals' relational awkwardness.[1] After the onset of clinical illness, the personal and societal costs escalate.

Innovative psychosocial treatment approaches have been partially effective in alleviating patients' disabilities. Case management and assertive community treatment have focused on providing services to severely im-

Received November 30, 1997; revised January 6, 1998; accepted January 16, 1998. From the Department of Psychiatry, University of Cincinnati College of Medicine, 4239 Elland Avenue, Cincinnati, Ohio 45229. Send correspondence to Dr. Stone at the above address.

paired individuals who require assistance in everyday living. Social skills training and vocational rehabilitation address aspects of social impairment. Psychoeducational programs, including family management, are valuable additions to the overall treatment armamentarium. Amidst this plethora of interventions, the place of psychotherapy, and in particular long-term group psychotherapy aimed at assisting patients in their efforts to improve their psychosocial functioning, has been relegated to lesser overall importance.

Research findings for psychotherapy of schizophrenia have not been robust, and as a result research efforts in this area have nearly vanished. This has occurred in part because of the hypothesized lack of effectiveness of psychotherapy when compared with medications and in part because of problems inherent in funding and conducting psychotherapy research. The difficulties are magnified when it comes to research on group treatment.

Reviews of psychotherapy for schizophrenia suggest that outpatient group treatment may help patients improve social functioning.[2,3] The treatment process is described as occurring in a two-step sequence: 1) a stabilization phase, which focuses on reducing and stabilizing positive symptoms and maintaining patients in the community; and 2) a rehabilitation phase, in which emphasis is on social adjustment relationships, interpersonal relations, and vocational possibilities.[4]

In the stabilization phase, treatment emphasizes patients continuing their medications and becoming more informed about their illness through supportive and educational strategies. This approach is particularly salient with the current practice of brief periods of hospitalization.

In the rehabilitation phase, the emphasis shifts to exploration of patients' capacities to form and sustain social relations and to determination of vocational capacities. Change in these latter sectors takes place much more slowly and is more difficult to assess. Yet it is in this rehabilitation phase that long-term psychotherapy, including group therapy, can have a significant impact on interpersonal and intrapsychic functioning. In this process patients can slowly gain greater control over their affects and develop insights into aspects of their relationships with others and with self.

The salience of addressing the social and interpersonal sectors of functioning in chronic mental illness was reported in a survey by Coursey et al.[5] Chronically ill patients in rehabilitation settings were asked to rate the importance of 40 therapeutic topics. The highest rated items clustered in a category described as "illness-intensified life issues" and encompassed independence, developing self-esteem, relationships, and feelings. Other categories, rated important at least two-thirds of the time, included adverse secondary consequences of the illness, self-management of the disorder, and coming to terms with the disability. These findings bring into focus patients' awareness of a continuity in their life and an appreciation that their condition has added a particularly devastating dimension to difficulties that may have been present prior to the onset of their clinical illness.

In the context of a history of social disappointments and emotional injury or rejection, it would be unrealistic to expect patients engaging in treatment to rapidly reveal their inner experiences and risk being retraumatized without thoroughly testing their environment. They will test and retest the therapist and the group to assess the safety of the situation. The clinician who "sticks with it" despite the personal difficulties—which may include both countertransferences and the real aspects of the relationships—will find opportunities to gain understanding of patients' efforts to cope, protect themselves, and work toward making positive changes in their lives.

THE CHANGING FACE OF PSYCHOTHERAPY

The quality of the relationship between patient and therapist is recognized as the foundation on which the therapist can assist the patient in gaining self-awareness and psychological

growth. Among the many theoretical advances there are two important strands: the consistent use of an empathic stance[6–8] and increasing attention to the therapist's affect.[9–11]

Self psychology has enabled clinicians to gain greater understanding of the patient's "use" of the therapist as a selfobject to fulfill missing or incompletely formed psychological functions, including containment of affects. Therapists can experience considerable dysphoria when they feel depersonalized and treated as a function. Recognizing this phenomenon as an archaic selfobject transference helps clinicians maintain their emotional equilibrium. In turn, therapists, by maintaining their balance, can more effectively help patients understand themselves.

A second valuable theoretical contribution, the "higher mental functioning" hypothesis described by Weiss and Sampson, explicates patients' interactions as conscious and unconscious testing in the therapeutic encounter. The tests are "designed" to determine if pathogenic beliefs in childhood should be sustained.[12–14] Skolnick,[15] working with psychotic and borderline individuals, writes, "No matter how withdrawn or bizarre these individuals may seem, or how much they try to destroy links with others, often there remain disguised pleas for help and attempts to communicate about the agonies of becoming and relating" (p. 243). Apprehending the confusing and disturbing affects evoked in the clinician in response to the "test" provides information about the patient's therapeutic hopes.

These and other theoretical advances have contributed to changes in therapeutic technique. Writing primarily within a self psychological framework, Lichtenberg et al.[16] note that they emphasize emotions as a guide for "appreciating self-experience and the desires, wishes, goals, aims, and values that come to be elaborated in symbolic forms" (p. 9). In psychotherapy of psychosis, affect "serves as the 'handle' that the psychotherapist 'grabs' in the effort to help the patient tolerate unbearable feelings and subsequently to reorganize his or her behavior in interpersonally productive ways" (p. 12).[9] The clinician's capacity to examine his or her affects stirred in the treatment transactions and then to use these responses to advantage becomes a central element in the conduct of treatment.

The focus on affects contributes to therapy becoming a more collaborative venture in which clinicians no longer make interpretations as the "truth," but instead offer interventions that encourage patients to make necessary "corrections." This stance recognizes that the patient's self experience is central, and that each participant has important emotions that can mutually enhance understanding. Thus, a patient's rejection or incomplete acceptance of a therapist's interpretation is not considered solely as resistance, but as a potential message regarding the impact on the patient of the therapist's interventions.

In group psychotherapy the complexity of communication is multiplied manifold. Interactions take place in relation to authority, to peers, or to the group as a whole. Particularly salient for individuals with chronic mental illness are fears of being unable to maintain a sense of themselves in a potentially threatening situation, with the possibility that they will experience further psychic disruption. The source of these potential injuries arises not only from the clinician, but from member-to-member interactions, or from member-to-subgroup or group-as-a-whole interactions.

In the process of emotionally joining a group, members may experience intense and potentially disorganizing affect stimulation that occurs in relation to others and within themselves. The group can come to represent or simulate life experiences, before or after the onset of the illness or in or outside the family. Old defensive and adaptive patterns will emerge, primarily as resistances or as tests to determine if the individual will be traumatized in the present as in the past. Thus the obvious cautious engagement and sense of mistrust displayed by most patients is understandable. Even with an optimal empathic response, change, if it is to occur, will take place slowly.

The model of the flexibly bound group is designed to collaboratively empower members and potentiate respect for each person's capacity to engage in treatment. The central element of the model is a group structure in which patients, after attending four sessions, choose the frequency with which they wish to attend meetings. This agreement, which reflects patient behavior but diminishes the potential for patients to feel pressure to attend each session as well as lessening the clinician's concerns about attendance, results in a group formation of core and peripheral subgroups. Group development is delayed, but over time the group becomes cohesive, and members can begin to address their intragroup relationships. In this context, it becomes possible to explore absences and for individuals to examine the reasons they give for their absences and gain insight into their failures to attend in accord with their agreement.

The following illustration examines the impact of a treatment structure that builds in flexibility of attendance, but without precluding discussion of absences in members learning about themselves and their affect states in relation to others.

ILLUSTRATION

The group, which has been in existence for over a decade, has achieved considerable stability, with a current census of 8 members. No persons have been added in the past 2 years. With the exception of Greg, who is diagnosed with mild mental retardation and a dependent personality disorder, all members have a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder. The group structure has evolved with a core subgroup of 5 persons who attend more than 75% of the meetings; 2 members who attend intermittently; and 1 who appears at widely spaced intervals. Members had engaged sufficiently to interact with one another and were no longer turning almost exclusively to the therapist.

The vignette illustrates patients' capacity to work with affects related to group absences and to gain insight into aspects of their behavior. Following a small meeting, with 2 or 3 persons present, it is possible to explore experiential aspects of group membership by focusing on subgroups (those who were present and those who were absent), thereby not isolating any single individual.

Sessions are 45 minutes long. All are videotaped, with the camera operator in the room and in view of the members. The vignette presented below was transcribed from the videotape and then edited for ease of presentation.

The session was particularly striking in members' movement of chairs. The seats had been set up in a horseshoe shape for videotaping but were pulled back by the patients in a manner that lessened the sense that they were sitting in a semicircle. However, within the first 12 minutes of the meeting, there were 5 instances of patients moving their seats more fully into their original position. At a point in the meeting at which the most distant member, Carl, seemed more engaged, the therapist invited him to bring his chair closer, a request with which he complied.

The meeting took place in mid-December. Three weeks previously, the group had not met because of the Thanksgiving holiday. Additionally, members had been informed there would not be a meeting between Christmas and the New Year holiday. These circumstances created a sense of discontinuity, and in the session prior to that illustrated in the vignette only Rita and Greg had been present. The focus of that session had been Greg's fears that he would be separated from his mother, whose deteriorating health made hospitalization appear imminent.

The following session began with 6 of the 8 members present. The therapist was 3 minutes late. After the therapist's entry into the room there was an initial subdued silence.

THERAPIST: What's been happening?

LORNA: You could say that we are all so sedated. [*laughs*]

RITA: Well, it's the first time in a couple of weeks that everybody has been here, I think. [*pulls in*

her chair] It seems like the last couple of times a lot of people weren't here. Last week it was just Greg and me.

JACK: I had a bad cold last week. I could have come, but I didn't want to spread my germs. But I didn't feel good either.

RITA: I wouldn't, either. That would have made you crabby.

JACK: I'm crabby enough as it is.

GREG: There was only Rita and I here.

RITA: We got a lot accomplished, though.

Following a brief interchange in which it is acknowledged that there have been prior meetings with only one or two members present, the interaction continues.

JACK: [*moves his chair into the circle*] So who did all the talking? Greg?

RITA: He had some problems at home he needed to talk about.

JACK: It was good that he had a chance to talk about them.

This comment seems to invite closure, but Rita (while moving her chair in more) continues the discussion of the previous week's topic, and Greg relates that his mother has improved and remains at home. Rick has wondered if prayer had helped her, and Greg responds that indeed they had prayed. When this discussion has run its course, the therapist intervenes.

THERAPIST: We were talking about one side of it: what it's like for Greg and Rita to be here. What about the others? What's it like to miss?

JACK: I needed to miss because I was sick, but the reason, I mean, I'm here practically every week. I could say I'm here every week. I just want to get away from it for a while. Not that I didn't get away Thanksgiving, but there was no group Thanksgiving. I wanted to be away when there was a group once. So I was glad to get away for a while.

RITA: I think it's good.

JACK: Once in a great while.

RICK: I was away for two or three weeks. I wanted to be here.

GREG: You didn't want to be here?

RICK: I *did* want to be here. I was having depression and stuff.

RITA: That's the worst part of it. When you want to be here and your depression keeps you away.

RICK: Yeah, well I wasn't doing anything else, either.

THERAPIST: What happens here? The two of you [Rita and Jack] are saying the same kind of thing. Though I would expect in part that others feel the same, can you say what it is about the group that you want to get away from, or is it something inside you or something about yourself?

JACK: Well, it's kind of equivalent to being on the job every day for a year and just the pressure every day. Every day and the routine, not a boring routine; the routine of it all and it's just like . . . I didn't go anywhere on vacation, but it felt like I was on vacation from the group, and I do feel better after I did that, and I do. [*Greg pulls his chair closer into the group*.]

LORNA: It's kinda like working on something. Each one of us has a different story.

THERAPIST: [*to Lorna*] Can you say more? Does it feel better to work on it at times alone or in the group? Can you identify when you might want to get away? What's happening inside you?

LORNA: Well, I never really want to get away, but I am asleep until 10:00 or 10:30 in the morning, which I have been doing lately. That kinda happens. It is good to get away at times. It is intense. All these . . . you know, everybody is so different.

THERAPIST: To feel others' problems at times feels intense.

LORNA: Yeah, I don't know exactly; it would be depression.

This theme related to missing meetings continues. Initially, Carl echoes the view that he "sort of likes missing," and he has so many things he is doing, but then he acknowledges that it is a relief not to have to listen to others. Rick indicates that the day he comes to the group is the only day he does anything, that otherwise his week is empty. Jack's ambivalence emerges, but he indicates that he would benefit from being away one time.

THERAPIST: It is different if one makes that decision [to be away] rather than the group not meeting. That is when you miss a week when you decide, rather than when there isn't a group scheduled.

JACK: It might be a week that there is no group scheduled, and you might really need one. And when you choose your own, maybe it's for a good reason. Maybe you are running away from something, but at least you are in control. [*moves his chair further into the circle*]

THERAPIST: [*to Rita*] Where does this fit for you?

RITA: I might handle what they do the same way. I might not come once in a while. Also I might handle it another way in the group. You used to say I talked too much. Maybe I talked too much because . . . what other people say upset me, and I . . . then it won't upset me so much.
JACK: So you didn't have to listen to somebody else.
RITA: I might. I'm saying that it could be.
RICK: You don't talk too much any more.
RITA: Maybe I'm getting better. [*pause*] I felt bad because nobody was coming because [*referring to a prior meeting*] me and Rick were talking all of the time.
CARL: It's so hot in here. I'm getting hot.
RITA: You're not getting sick, are you?

Not hearing the metaphor, the therapist refocuses back to feelings about regularly attending the meetings. Jack begins to express the idea that he wishes attendance were mandatory. He elaborates that he feels tension while in the group and that he is "forced to think harder in here than anyplace else." The therapist again intervenes, suggesting that each individual has his or her own "internal monitor" that helps regulate attendance, and asks again for descriptions of the inner feelings. Carl, who acknowledges that being busy is an excuse, says that the group is the place where he talks to people the most, except when he is on the phone. At this point, the therapist invites Carl to move his chair into the group, and he complies. These interactions took place within the initial 15 minutes of the meeting.

DISCUSSION

This vignette illustrates the capacity of some chronically ill persons to engage in a discussion of the intensity of their feelings stimulated by participating in group psychotherapy, and to gain insight into aspects of their self-protective behaviors. Participating in group therapy provides opportunities for patients to become more flexible in managing affects. A group also represents a threat, since patients fear that they will be unable to maintain their personal boundaries and will be flooded with their own and others' affects. The result is a tendency to miss sessions or terminate treatment.[17] However, absences can be understood not only as a defense, but as a test as well. The test might be formulated, "If I assert my independence and decide not to come to a meeting, will I be criticized, punished, neglected, or ignored altogether?" If this and similar tests are passed, patients may increase their trust in others and begin to tolerate and integrate their affects.

Rita begins with the bland statement that people have not been present for several weeks. The affective meaning of this is not initially apparent but emerges in the ensuing process. Jack indicates that his absence was due to his cold, but his gratuitous comment, "I didn't want to spread my germs," may be understood as a metaphor for fears that he would emotionally infect others. The interchange focuses on being "crabby" as the uncomfortable emotion.

The emotionally salient central theme of separations and losses is illustrated by Rita's continued discussion with Greg of his mother's illness and the possibility of her requiring hospital care. The dyadic form of this discussion, as if only Rita and Greg were present, reenacted the prior week's session. The therapist's inquiry framed members' enactment as belonging to one of two subgroups: those present and those absent the preceding week. The interpretation emerged from the therapist's listening "and not bother[ing] about keeping anything in mind."[18] Such interventions have been labeled "disciplined spontaneous engagements" and represent the therapist's "generative intent" emerging from knowledge of the patients.[16] Contributing to the intervention was the therapist's experience with group treatment and his appreciation that patients were more willing to share feelings and engage in the group if they were part of a subgroup.[19]

The model of the flexibly bound group does not preclude discussion of absences. Over time a rhythm of attendance becomes established, and members know, and respond, when others do not attend in accordance with their usual agreement. In this session, members' responses ranged from describing meetings as boring to describing them as intense.

This latter feeling is addressed by Jack and by Carl, who indicates that it is a relief not to have to listen to others.

After the therapist differentiates between missing due to canceled sessions and missing through a patient's personal decision, Jack is able to summarize the central theme as a conflict that "you have control even if you are running away." Lotterman[20] (p. 115) reflects on the importance of control in the psychotherapy of patients diagnosed with schizophrenia:

> Schizophrenic patients are enormously sensitive to intrusion and what to them feels like coercion. If they feel invaded or violated, they will flee. . . . [They] can travel far down the path of self-destruction with little concern, and can quickly bring themselves and their treatments to the brink of collapse. . . . The therapist is caught between the Scylla of overactivity and intrusiveness, and the Charybdis of being lulled by the patient's bland denial until suddenly the treatment is destroyed.

The flexibly bound group model enables the therapist to comfortably permit missing, which thereby allows patients to maintain a degree of sanction-free control.

A paradox is involved in discussing patients' fears of being overwhelmed and accepting, if not encouraging, their choosing to distance themselves. The therapist, by verbalizing patients' needs to have control, accepts their needs to create personal space and distance. Members are then prepared to explore fears of losing control and being unable to manage personal boundaries. Out of this therapeutic stance emerges the patients' wish for involvement, which had been partially obscured. The members' wish for greater engagement is enacted in behavior as they draw their chairs into the group circle.

Coursey et al.[5] reported that 84% of the surveyed schizophrenic patients preferred shorter, less frequent individual sessions (less than 30 minutes, less than once a month). With this treatment dosage, ¾ of respondents indicated that therapy had brought positive or very positive changes to their lives. Thus it is not surprising that attendance in a more complex social setting of a group will be linked to absences. Over time, absences may decrease and greater engagement take place. Moving one's chair outside the circle represents a mini-distancing. When patients have a sense of control and acceptance, they are freer to diminish that distance. Jack's comment equating running away with control was directly linked to his moving his chair into the circle.

The therapist, not consciously recalling Rita's history of monopolizing meetings, turned to her to ask where this fit in for her. Rita said that she used a different behavior (talking) to achieve the similar goal of creating space. In this process, Rita's self-reflection demonstrated the paradox and represented a step in addressing a more difficult issue, her anxious fantasy that her excessive talking had been the cause of others' recent absences.

I would suggest that the integrative act (insight) of linking talking with control enhanced Rita's self-esteem. An experience of discovery and a concomitant experience of self-efficacy had taken place. In that context, Rita revealed her thought that she was the cause of the absences. This process reverses the more typical sequence in which insight in the present leads to insight into the past. The past and present are intertwined, and integration of the two does not follow a set formula.

For Carl, who had positioned himself on the group periphery, this sequence turned up the "heat" of involvement, and he complained. His position is echoed by Jack, who states how he is forced to think harder in the group than anywhere else. After the therapist frames the situation in terms of an "internal monitor," thereby diminishing the risk of group-wide criticism, Carl exposes his behavior as an excuse. At this point Carl is able to accept the therapist's invitation to move his chair more into the group circle.

COMMENT

Schizophrenic patients are not prone to be introspective. Most individuals are content to

seal over their psychotic experience, and only a small proportion are motivated to integrate the experience as part of their lives.[21] An important contribution to patients' difficulties in engaging in treatment is their lack of insight into their illness behaviors. Deficits in insight exist even in stable outpatients and contribute substantially to their limited participation in social activities and interpersonal communication.[22] By achieving insight into their illness, patients may lower barriers to engagement. Involvement in the group process may induce a positive, reinforcing spiral of insight and an increasingly emotionally satisfying engagement both in and out of the group setting.

Acknowledging that others are important and meaningful is a risky business. Many experiences preceding the onset of the illness have been perceived as emotionally toxic. With the establishment of a chronic course, patients are subjected to further trauma as aspects of their illness further alienate them and disrupt social relationships. The lack of insight is often manifested as denial of need for others. Thus, the process of testing to determine the nature of others' responses is an expectable interpersonal process.

Additional major components of the schizophrenic illness are the negative symptoms of apathy, low motivation, and disengagement, which may be an amalgam of biological and emotional elements. As demonstrated in studies of expressed emotion, these affective experiences, which often become particular targets for family hostility, may override the therapeutic benefit of medication.[23,24] Patients' vulnerability to injury represents a significant therapeutic challenge as they place barriers to forming potentially therapeutic relationships, and they are particularly alert to any transaction that criticizes their distancing and self-protective mechanisms.

Clinicians face a formidable task of helping shape a group milieu in which patients will abandon their preferences for sealing over and for brief, widely spaced sessions and move to a position in which they will risk reflecting and searching for meaning in their interactions. A central element in achieving these goals is emotional affirmation that will sustain patients through the inevitable affective stimulation intrinsic to group interactions.

Bacal[25] asserts that patients are seeking "optimal responsiveness," not optimal frustration. Similarly, Teicholz[26] notes that "frustration becomes not a positive developmental principle in its own right, but an inevitable concomitant of the human condition, to which specific environmental response is required in order to help the developing child or the patient master otherwise overwhelming affective experience" (p. 148). The intensity of an individual's response to a "hurtful" interaction (as experienced by the individual, even if the interaction is considered "appropriate" by the observer) is a product of the person's biological heritage, his or her developmental influences, and the current environment. Experiences of optimal responsiveness, particularly to affectively significant transactions, affirm the value of the injured person, a process that stabilizes the individual and encourages growth.

The clinical example illustrates a therapist's interventions that are based on valuing the establishment of a positive therapeutic climate and appreciating patients' communicative efforts as transmitted by missing sessions. These behaviors are understood not merely as resistances, but as self-protective and self-stabilizing responses, particularly in the sector of managing affect. Within the framework of the therapist's recognizing the behaviors as tests, members may feel appreciated and empowered, and they may be able to explore affects that were previously walled off and achieve insight into aspects of their interactions.

We have incomplete knowledge of the pathophysiology of schizophrenia. Current treatment models are sufficiently broad to take into account biological vulnerability and psychosocial stress. Inevitably, there will be fluctuations in patients' clinical state as they experience stress arising from intrapsychic or interpersonal conflicts. With their presumed biological deficits, patients with schizophrenia appear to need extended periods of treatment,

requiring therapeutic persistence, patience, tolerance of ambiguity and strong affects, and a willingness to stick with the patient.[27] One session in which patients exhibit self-reflection and insight into their behavior represents only a small step on their road to improved functioning. Many fluctuations will occur in the treatment process, and therapeutic persistence is essential. The rewards for both therapist and patient, however, are substantial.

The author thanks Edward B. Klein, Ph.D., Marvin Skolnick, M.D., and Esther Stone, MSSW, for their thoughtful comments on this manuscript.

REFERENCES

1. Walker E, Lewine RJ: Prediction of adult-onset schizophrenia from childhood home movies of the patients. Am J Psychiatry 1990; 147:1052–1056
2. Mosher LR, Keith SJ: Psychosocial treatment: individual, group, family, and community support approaches. Schizophr Bull 1980; 6:10–41
3. Schooler NR, Keith SJ: The clinical research base for the treatment of schizophrenia, in Health Care Reform for Americans With Severe Mental Illnesses: Report of the National Advisory Mental Health Council (US Dept of Health and Human Services). Washington, DC, US Government Printing Office, 1993, pp 22–30
4. Breier A, Strauss JS: The role of social relationships in the recovery from psychotic disorders. Am J Psychiatry 1984; 141:949–955
5. Coursey RD, Keller AB, Farrell EW: Individual psychotherapy and persons with serious mental illness: the clients' perspective. Schizophr Bull 1993; 21:283–301
6. Bacal HA: The essence of Kohut's work and the progress of self psychology. Psychoanalytic Dialogues 1995; 5:353–366
7. Kohut H: The Restoration of the Self. New York, International Universities Press, 1977
8. Kohut H: How Does Analysis Cure? Chicago, University of Chicago Press, 1984
9. Garfield DAS: Unbearable Affect: A Guide to the Psychotherapy of Psychosis. New York, Wiley, 1993
10. Semrad E, Van Buskirk D: Teaching Psychotherapy of Psychotic Patients. New York, Grune and Stratton, 1969
11. Stone WN: On affects in group psychotherapy, in The Difficult Patient in Group, edited by Roth BE, Stone WN, Kibel HD. Madison, CT, International Universities Press, 1990, pp 191–208
12. Weiss J, Sampson H, and the Mount Zion Psychotherapy Research Group: The Psychoanalytic Process: Observations and Empirical Research. New York, Guilford, 1986
13. Weiss J: How Psychotherapy Works: Process and Technique. New York, Guilford, 1993
14. Stone WN: Group Psychotherapy for People with Chronic Mental Illness. New York, Guilford, 1996
15. Skolnick MR: Intensive group and social systems treatment of psychotic and borderline patients, in Ring of Fire: Primitive Affects and Object Relations in Group Psychotherapy, edited by Schermer VL, Pines M. London, Routledge, 1994, pp 240–274
16. Lichtenberg JD, Lachmann FM, Fosshage JI: The Clinical Exchange: Techniques Derived from Self and Motivational Systems. Hillsdale, NJ, Analytic Press, 1996
17. Yalom ID: The Theory and Practice of Group Psychotherapy, 4th edition. New York, Basic Books, 1985
18. Freud S: Recommendations to physicians practicing psycho-analysis (1912), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, vol 12, translated and edited by Strachey J. London, Hogarth Press, 1958, pp 109–120
19. Agazarian Y: Systems theory and small groups, in Comprehensive Group Psychotherapy, 3rd edition, edited by Kaplan HI, Sadock BJ. Baltimore, Williams and Wilkins, 1993, pp 32–44
20. Lotterman A: Specific Techniques for the Psychotherapy of Schizophrenic Patients. Madison, CT, International Universities Press, 1996
21. McGlashan TH, Levy ST, Carpenter WT: Integration and sealing over: clinically distinct recovery styles from schizophrenia. Arch Gen Psychiatry 1975; 32:269–272
22. Dickerson FB, Boronow JJ, Ringel N, et al: Lack of insight among outpatients with schizophrenia. Psychiatric Services 1997; 48:195–199
23. Kuipers L: Expressed emotion: a review. British Journal of Social and Clinical Psychology 1979; 18:237–243
24. Runions J, Prudo R: Problem behaviors encountered by families living with a schizophrenic member. Can J Psychiatry 1983; 28:382–386
25. Bacal HA: Recent theoretical developments: contributions from self psychology theory, in Handbook of Contemporary Group Psychotherapy, edited by Klein RH, Bernard HS, Singer DL. Madison, CT, International Universities Press, 1992, pp 55–85
26. Teicholz JG: Optimal responsiveness: its role in psychic growth and change, in Understanding Therapeutic Action: Psychodynamic Concept of Cure, edited by Lifson LE. Hillsdale, NJ, Analytic Press, 1996, pp 139–161
27. Fenton WS, Cole SA: Psychosocial therapies of schizophrenia: individual, group, and family, in Synopsis of Treatments of Psychiatric Disorders, 2nd edition, edited by Gabbard GO, Atkinson SD. Washington, DC, American Psychiatric Press, 1996, pp 425–438